

# Time for a new approach?

### The primary care practitioner

#### INTRODUCTION

The GP workload and workforce crises have led to a number of NHS-led initiatives to increase the number and variety of allied healthcare professionals (AHCPs) available in primary care.<sup>1-3</sup> GPs and practice managers have sought to fill empty GP posts with AHCPs without determining first whether the AHCP had the clinical knowledge, skills, and experience to work competently and safely in this role, and without appreciating the limitations in working autonomously and in prescribing that some AHCPs have. At present, AHCPs and GPs work in parallel, and their training programmes reflect this. A shared role would lead to a shared curriculum in which the AHCP and GP would have clearly defined roles and their training would be integrated. This would enable the role of the AHCP and the GP to develop synergistically, rather than in isolation. This article explores the benefits to both AHCPs and GPs in adopting this approach.

#### THE CURRENT SITUATION

At present, AHCPs tend to be employed by the practice to perform certain tasks, such as seeing patients with minor illness, or performing home visits, and it is this that often determines whether a physician associate, nurse, or paramedic is recruited. For other tasks, a physiotherapist or clinical pharmacist might be more appropriate. However, a lack of familiarity with the training programmes and regulations that govern these different AHCPs can lead to practices assuming that the AHCP has the appropriate training, experience, and scope of practice to work in these roles competently and safely, which is not always the case. For example, an AHCP who is not permitted to prescribe but is seeing patients with minor illness will not only have less impact on reducing the GP workload but may also have a negative impact on the stress levels of GPs whose consultations are being interrupted to sign prescriptions, particularly if they are concerned as to the medicolegal aspects of signing prescriptions for patients whom they have not seen themselves.<sup>4,5</sup>

The absence of an integrated approach to healthcare provision in primary care has resulted in GPs and AHCPs working independently of one another in the practice, which creates problems not

---

*“The absence of an integrated approach to healthcare provision in primary care has resulted in GPs and AHCPs working independently of one another in the practice ...”*

---

only with workload planning but also in developing new roles for both the AHCP and the GP.<sup>6</sup> More importantly, however, it prevents practices from adopting an integrated approach to workload planning, in which the role of the GP and the AHCP working together as a single unit of care is considered. The creation of a new AHCP, the primary care practitioner (PCP), would not only ensure that there was an AHCP who was capable of performing all the tasks required of them, but it would also enable GPs to know which tasks could be devolved to this AHCP, and to make adjustments to their own role within the practice accordingly. It is the concept of a shared role that is important in determining which parts of that role are performed by the PCP, and which by the GP, as this will enable both the PCP and the GP to share not only the workload, but also a training curriculum.

#### A NEW APPROACH

For the primary care workforce to develop in a more coordinated way, GP and PCP training needs to become integrated, rather than remaining separate, as it is at present. This sharing of the primary care curriculum between GPs and PCPs will enable a better understanding of each other's roles and it will assist GPs in being able to plan changes to their own training programme, in the knowledge that they can delegate tasks to an AHCP who is both competent and safe to perform these tasks. This will also determine the depth, breadth, and

duration of training required, along with the clinical skills and experience necessary to deliver both PCPs and GPs to the primary care workplace. The integration of PCP and GP specialist registrar training would have many benefits, including a better understanding of each other's training, clinical roles, and professional governance, as well as increased confidence in the capability of the PCP among GPs. A modular approach to PCP training would provide opportunities for other AHCPs to undergo PCP training without completing the whole training programme.

The Royal College of General Practitioners would play a vital role in setting the curriculum for PCP training, including determining the core competencies and clinical experience required. The involvement of GPs in the teaching and assessment process would not only enhance the quality of the teaching but it would also give GPs a better understanding of what the role of the PCP is within the primary care workplace. GP involvement could also help with understanding how the role of the GP could change once tasks — such as reading the hospital post, screening incoming laboratory results, seeing patients with minor illness, and managing and reviewing patients with acute-on-chronic illness at home — are performed by the PCP, instead of by a GP. The opportunity for GPs to have more time to consult with patients and to reflect on cases could be combined with more GP-with-a-special-interest-level training

---

*“For the primary care workforce to develop in a more coordinated way, GP and PCP training needs to become integrated, rather than remaining separate, as it is at present.”*

---

*“... the only way to resolve the workload and workforce crises in primary care is to follow the US example and develop a primary care-specific AHCP, whose training and working practices are fully integrated with those of the GP”*

to enable GPs to provide more services within the practice and introduce new care pathways, similar to those currently offered in Ambulatory Care Units. The ability to offer these services at present is often limited by a combination of a lack of time and a lack of training, which are both factors that could change with PCPs taking over part of the current GP workload.

The presence of a PCP within the practice would enable the role of the GP to evolve and become similar to that of the hospital consultant, whose role is not to see every patient who comes to the clinic but to act as the team leader, supporting and training other members of the team and providing expert clinical input when required. Continuity of care would be provided by the practice, rather than by an individual, with each member of the practice contributing to the care of the patient in a way that was commensurate with their level of training, skills, and clinical experience. Until a more joined-up approach to training and development is taken, it is unlikely that either cost or care effectiveness can be maximised within the practice, as the current situation frequently involves the duplication, or half-completion, of tasks by AHCPs and does not allow GPs to devolve enough of their workload to AHCPs to make the required changes to their own role. A primary care-specific AHCP, combined with a GP working in a different role, might prove to be a partial solution to the GP workload and workforce crisis, both in the short and the long term.

In the US, where there has always been a shortage of family doctors, the response was to develop PAs in family practice to support the GP, for which they receive an additional year of postgraduate training to work in this role.<sup>7</sup> A description of the role of the PA in family practice provides an insight into how PCPs could work in primary care in this country and the different roles that they could play, depending upon the size, rurality, and needs of the individual practice. The existing model of primary care here is heavily dependent upon the availability of GPs to staff that model and, in the absence of the promised ‘army of new GPs’, the only way to resolve the workload and workforce crises in primary care is to follow the US example and develop a primary care-specific AHCP, whose training and working practices are fully integrated with those of the GP.

**Paul Silverston,**

Visiting Professor of Primary Care, University of Suffolk, Ipswich, and Visiting Professor, Anglia Ruskin University, Cambridge, UK.

**Funding**

None.

**Provenance**

Freely submitted; not externally peer reviewed.

**Competing interests**

The author is involved in primary care workforce development.

DOI: <https://doi.org/10.3399/bjgp19X700589>

**ADDRESS FOR CORRESPONDENCE**

**Paul Silverston**

The Walled Garden, 9 Church Lane, Snailwell, Cambs, CB8 7LZ, UK.

Email: [paul.silverston@btinternet.com](mailto:paul.silverston@btinternet.com)

**REFERENCES**

1. NHS England. *General practice forward view*. 2016. <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf> [accessed 15 Nov 2018].
2. Roland M, Barber N, Howe A, *et al*. *The future of primary care: creating teams for tomorrow. Report by the Primary Care Workforce Commission*. Health Education England, 2015. [https://ueaeprints.uea.ac.uk/55636/1/The\\_future\\_of\\_primary\\_care.pdf](https://ueaeprints.uea.ac.uk/55636/1/The_future_of_primary_care.pdf) [accessed 15 Nov 2018].
3. Nelson P, Martindale AM, McBride A, *et al*. Skill-mix change and the general practice workforce challenge. *Br J Gen Pract* 2018; DOI: <https://doi.org/10.3399/bjgp18X694469>.
4. McCartney M. Margaret McCartney: Are physician associates just ‘doctors on the cheap’? *BMJ* 2017; DOI: <https://doi.org/10.1136/bmj.j5022>.
5. Drennan VM, Halter M, Joly L, *et al*. Physician associates and GPs in primary care: a comparison. *Br J Gen Pract* 2015. DOI: <https://doi.org/10.3399/bjgp15X684877>.
6. Jones R. Deconstructing the doctor. *Br J Gen Pract* 2017; DOI: <https://doi.org/10.3399/bjgp17X692177>.
7. PhysicianAssistantEDU.org. How to become a PA specialized in family medicine. <https://www.physicianassistantedu.org/family-medicine/> [accessed 15 Nov 2018].